U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 May 2003

CASE NOS. 2002-BLA-298
2002-BLA-299

In the Matter of

FRANK KOVALCK (Deceased),
ANNA KOVALCK (Widow),
Claimants

v.

CONSOLIDATION COAL CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

C. Patrick Carrick, Esquire
For the Claimants

William S. Mattingly, Esquire
For the Employer

Before: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from claims for benefits filed by Frank Kovalck, a now deceased coal miner, and Anna Kovalck, his surviving spouse, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of

Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on October 9, 2002 in Morgantown, West Virginia. The parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open for the submission of additional evidence and post-hearing briefs. The briefs were due on December 9, 2002 (TR 7).

The record consists of the hearing transcript, Director's Exhibits 1 through 123 (DX 1-123), Administrative Law Judge Exhibit 1(ALJX 1), Employer's Exhibits 1 through 3 (EX 1-3), and Claimant's

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. At the formal hearing held on August 8, 2001, the parties agreed to proceed with the hearing, while reserving the right to challenge the application of the new regulations if they felt prejudiced thereby (TR 16-17). On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit issued its decision in *National Mining Ass'n, et al v. Dep't of Labor*, _____F.3d_____(D.C. Cir. June 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. However, as stated in revised 20 C.F.R. §725.2, the provisions of §725.309 (*i.e.*, duplicate or additional claims) are not applicable to claims pending on January 19, 2001. Furthermore, the provisions of revised 20 C.F.R. §718.205(c)(5) regarding pneumoconiosis hastening the miner's death simply codifies existing case law. Accordingly, I find that under the particular facts herein, the Amendments do not affect the outcome of this claim.

Exhibit 1.[2] In addition, the closing arguments of the respective parties have been considered.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On May 18, 1970 (DX 18-43) and January 16, 1976 (DX 18-1), Frank Kovalck, a former coal miner, filed applications for black lung benefits under the Act. Following the passage of the Black Lung Benefits Reform Act of 1977, Mr. Kovalck also filed an election card, dated March 31, 1978 (DX 18-55). The foregoing claims were repeatedly denied (DX 18-51, DX 18-52, DX 18-53, DX 18-54). Following a formal hearing before Administrative Law Judge James W. Kerr, Jr., on July 14, 1981 (DX 18-17), Judge Kerr issued a Decision and Order-Rejection of Claim, dated March 30, 1982 (DX 18-18). Although the Claimant appealed Judge Kerr's decision (DX 18-35), the Board ultimately dismissed the appeal on grounds that it had been abandoned, as set forth in the Board's Order, dated February 27, 1986 (DX 18-42). The miner did not appeal or take any further action within one year of the Board's Order, dated February 27, 1986. Accordingly, the above-referred claims have been finally denied and administratively closed.[3]

On November 8, 1988, the miner filed another claim (DX 19-1), which was denied by the District Director on May 2, 1989 (DX 19-18). On or about May 19, 1989, Claimant filed a timely Notice of Appeal directly to the Benefits Review Board, as instructed by the District Director under then existing case law (DX 19-19; *See* DX 19-18, Notice of Appeal Rights). However, on December 29, 1989, the Board issued an Order dismissing the appeal on the grounds that the Claimant had failed to submit a Petition for Review and Brief, nor had Claimant responded to the Board's Order to show cause, dated August 30, 1989 (DX 23). The miner did not appeal or take any further action within one year of the Board's Order, dated December 29, 1989. Accordingly, the 1988 has also been finally denied and administratively closed.

On March 20, 1992, Mr. Kovalck filed the current miner's claim for benefits under the Act (DX 1), which was granted by the District Director (DX 11,12). By letter, dated September 22, 1992,

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[2] Pursuant to leave granted at the formal hearing (TR 7), Claimant submitted the autopsy report of Dr. Jeffrey A. Kahn, dated October 10, 2002, under cover letter, dated October 18, 2002. Furthermore, Employer counsel's letter, dated December 9, 2002, not only refers to Employer's closing argument, but also expressly states that "Consolidation Coal Company has no objection to Claimant's Exhibit 1." Accordingly, Dr. Kahn's report, dated October 10, 2002, has been marked and received in evidence as Claimant's Exhibit 1 (CX 1).

[3] By letter dated December 1, 1987, Claimant's counsel requested the status of the appeal. However, as set forth in the Board's Order, dated June 30, 1988, the Board construed the letter as a reconsideration request. Since the Board found the reconsideration request was untimely, it was denied (DX 18-32).

Employer filed a timely request for a formal hearing (DX 13). Following the development of additional evidence and various procedural delays, an administrative law judge issued a "Decision and Order-Denial of Benefits on Remand," dated March 19, 1998 (DX 37). Following Claimant's appeal (DX 36), Employer's correspondence (DX 48), and Director's Motion for Remand (DX 50), the Board issued an Order, dated November 3, 1998, vacating the above-referred decision and remanding the case to the Office of Administrative Law Judges for a hearing before all interested parties (DX 51).[4] Following the transmittal of the miner's case to this Office, Administrative Law Judge Michael P. Lesniak issued a Notice, dated July 7, 1999, scheduling the formal hearing date of August 3, 1999 (DX 56). However, in the interim, the miner passed away on March 2, 1999 (DX 79). Accordingly, Judge Lesniak issued an Order Granting Continuance, dated July 19, 1999 (DX 59).

On January 31, 2000, Mr. Kovalck's surviving spouse, Anna Kovalck (hereinafter referred to as "Claimant" or "widow") filed an application for survivor's benefits (DX 1), which was denied by the District Director's office on July 20, 2000 (DX 116). In correspondence, dated July 26, 2000, Claimant filed a timely request for a formal hearing regarding the widow's claim, as well as the still viable miner's claim (DX 120).

As stated above, a formal hearing was held before the undersigned on October 9, 2002; and, the record was held open until December 9, 2002.

Issues

The primary contested issues in the miner's and widow's claim, respectively, are as follows:

Miner's Claim:

1. Whether the miner was totally disabled (by a respiratory or pulmonary impairment).
2. Whether the miner's disability was due to pneumoconiosis.
3. Whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. §725.309.

Widow's Claim:

1. Whether the miner's death was due to pneumoconiosis.

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[4] In the Decision and Order, dated March 19, 1998, the administrative law judge failed to list Consolidation Coal Company as a party, nor make any reference to the responsible operator issue. Furthermore, the administrative law judge referred to a formal hearing on July 5, 1995, which apparently was never held. Moreover, the record indicates that the Employer had not been served with the administrative law judge's Decision and Order, or other evidence (DX 37,48, 50,51).

(TR 9-11).[5]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

A. Coal Miner

The Employer conceded, and I find, that Mr. Kovalck engaged in coal mine employment for at least 42 years (TR 10).

B. Responsible Operator

The Employer conceded, and I find, that Consolidation Coal Co., is the properly designated responsible coal mine operator in this case (TR 10-11).

C. Dependents

The Employer conceded, and I find, that Frank Kovalck had one dependent for purposes of possible augmentation of benefits under the Act; namely, his spouse, Anna Kovalck. However, the Anna Kovalck, the surviving spouse, has no dependents (TR 10; DX 71).

D. Personal and Employment Background

The former miner, Frank Kovalck, was born on January 9, 1913; he completed a 6th grade education. He married Anna Kovalck (nee Cieniawski) on December 30, 1939. They remained married until his death on March 2, 1999 (DX 1, 71).

Mr. Kovalck left the coal mines on January 9, 1976. On the current miner's application, Mr. Kovalck stated that he stopped working in or around the coal mines because he was "Disabled/Retired" (DX 1). Although no one testified at the formal hearing on October 9, 2002, Mr. Kovalck testified at a prior hearing held before Judge Kerr on July 14, 1981 (DX 18-17). His last usual coal mine job was as a loading machine operator (DX 18-17, p. 17). The job duties included the following: handling his own cable on the loading machine; handling the miner cable of the miner ahead of him; helping to drill holes in the roof; shovel; help hang tubes. Thus, the job did not simply entail sitting at the loading machine and operating the loaders (DX 18-17, pp. 18-21). In addition, the miner stated that he decided to quit work in January 1976, because of his breathing problems, which he had first noticed fourteen or fifteen years earlier (DX 18-17, pp. 21-22). In addition, the miner acknowledged that he had some arthritis in his arms and shoulders, as well as knee pain (DX 18-17, pp. 30-31). Furthermore, the miner testified that he had taken nitroglycerin, in 1978; however, he stated that it was prescribed for a gall bladder attack, not for chest pains (DX 18-17, pp. 35-36). Notwithstanding the miner's complaints of shortness of breath, he was not

[5] The Employer also preserved its challenge to the constitutionality of the Act and regulations regarding the miner and widow's claims for appellate purposes (TR 10-11).

taking breathing medicine as of the July 14, 1981 hearing (DX 18-17, p. 36). At that time, the miner acknowledged a cigarette smoking history beginning at age twenty, twenty-one, or twenty-two (*i.e.*, 1933, 1934, or 1935) and ending on August 1, 1980. However, Claimant also testified that he had quit smoking several times and started up a little bit; and, that he had smoked less than 1/3 of a pack per day (DX 18-17, pp. 36-38).

Medical Evidence

The case file contains numerous chest x-ray interpretations, pulmonary function studies, arterial blood gas test results, and medical opinions. With the exception of the post-hearing report of Dr. Kahn (CX 1), the medical evidence is adequately summarized in Employer's Pre-Hearing Report (ALJX 1). Except as otherwise modified or superseded herein, the medical evidence as set forth in Employer's Pre-Hearing Report (ALJX 1) is incorporated by reference herein. This obviates the necessity for a complete repetition of such evidence. Nevertheless, I have considered all the relevant evidence. Moreover, the miner's current claim is a duplicate one involving limited issues, and the only contested issue in the widow's claim pertains to the death due to pneumoconiosis issue.

As outlined above, Mr. Kovalck filed applications, dated May 18, 1970 (DX 18-43) and January 16, 1976 (DX 18-1), respectively. Furthermore, he filed an election card, dated March 31, 1978 (DX 18-55). The final *substantive* denial was issued by Judge Kerr in his Decision and Order-Rejection of Claim, dated March 30, 1982 (DX 18-18). In summary, Judge Kerr found the presence of simple pneumoconiosis, as stipulated by the Employer, on the basis of the x-ray evidence. Accordingly, the interim presumption was invoked pursuant to §727.203(a)(1) of the regulations. However, Judge Kerr stated, in pertinent part, that "the overwhelming preponderance of the evidence indicates that, although Claimant [Mr. Kovalck] suffers from a lung condition, he is not totally disabled by it." Therefore, Judge Kerr found that the miner did not qualify for benefits under Part 727 of the regulations. Since the underlying claims were filed prior to March 31, 1980 (*i.e.*, the effective date of the Part 718 regulations), Judge Kerr also considered the case under the Part 410 regulations and stated, in pertinent part, that the miner had also failed to establish total disability and/or total disability due to pneumoconiosis thereunder (DX 18-18). The foregoing claims were finally denied on procedural grounds when the Board dismissed Claimant's appeal, because it had been pursued (DX 18-42).

As stated above, the miner's claim filed on November 18, 1988 (DX 19-1) was denied on the merits by the District Director on May 2, 1989 (DX 19-18). The District Director stated that he evaluated the case under Part 718, and found that the miner had failed to establish a material change in conditions. In making this determination, the District Director noted that the miner had still not established the elements of "total disability" or "causation" (DX 19-18). The foregoing claim was finally denied on procedural grounds when the Board dismissed Claimant's appeal on December 29, 1989, because the appeal had not been pursued (DX 23).

Since the presence of pneumoconiosis and its causal relationship to Mr. Kovalck's coal mine employment history has, again, been conceded by Employer (TR 10), and there is no credible evidence that

the miner suffered from complicated pneumoconiosis (ALJX 1), further analysis of the x-ray evidence is unnecessary. Moreover, in view of the progressive nature of pneumoconiosis, the most relevant medical evidence in the miner's claim consists of the recent pulmonary function, arterial blood gas test results and medical opinions, which address the total disability and causation issues. Furthermore, the most relevant medical evidence in the widow's claim includes the medical (pathology and non-pathology) opinion evidence which addresses the death due to pneumoconiosis issue.

A. Pulmonary Function Studies

The record reveals numerous pulmonary function studies throughout the period from March 9, 1970 through October 30, 1992 (ALJX 1). The reported heights have varied throughout that period. However, the general trend indicates that the miner's height decreased with age. In summary, I find that the miner's height was approximately 71" for the period from March 9, 1970 through February 1, 1984, when he was 71 years old. However, for the period from July 29, 1988 through October 30, 1992, the miner's height had decreased to approximately 70." (ALJX 1).

During the period from March 9, 1970 through November 30, 1990, the pulmonary function studies (before and after bronchodilator) were clearly nonqualifying under the applicable regulatory criteria set forth in Part 718, Appendix B. The more recent pulmonary function studies yielded mixed results.[6] The April 17, 1991 test results were nonqualifying before bronchodilator, but qualifying after bronchodilator. On the other hand, the April 29, 1992 study yielded qualifying values before bronchodilator and nonqualifying results after bronchodilator. Finally, the October 30, 1992 pulmonary function results were nonqualifying before bronchodilator, but qualifying after bronchodilator (ALJX 1). In summary, the pulmonary function studies through November 30, 1990 clearly did not establish total disability. The recent ventilatory studies neither preclude nor establish total disability. Accordingly, I find that, even if I accord greater weight to the more recent pulmonary function evidence, Claimant has failed to meet her burden of establishing total disability based on the preponderance of such evidence.

B. Arterial Blood Gas Studies

The case file includes various arterial blood gas studies throughout the period from September 18, 1977 through January 13, 1999 (ALJX 1). During the period from September 18, 1977 through December 21, 1988, the arterial blood gas results fluctuated. The September 18, 1977 (resting) and July 29, 1988

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[6] For a person of the miner's found height (approximately 70"), and age at time of testing (78 or 79), the qualifying FEV.1 value is 1.88. This is based upon the standards set forth in Part 718, Appendix B, for a height of 70.1" and an age of 71 years old, which is the oldest age listed in the regulations. Thus, the recent qualifying tests include FEV1 values which are barely qualifying, while the recent nonqualifying studies include FEV1 results which are almost qualifying (ALJX 1).

(resting and exercise) tests were qualifying under the regulatory criteria set forth in Part 718, Appendix C. On the other hand, the January 5, 1979 (resting), August 1, 1979 (resting), February 25, 1981 (resting), and December 21, 1988 (resting) blood gas studies were not qualifying. Moreover, the arterial blood gas studies (resting and exercise) throughout the period from April 29, 1992 through January 13, 1999 were nonqualifying. In view of the foregoing, I find that Claimant has failed to meet her burden of establishing total disability based on the preponderance of the arterial blood gas evidence.

C. Medical Opinion Evidence

The medical opinion evidence is mixed regarding the total disability and causation issues. Furthermore, several of the pre-autopsy medical opinions the presence of pneumoconiosis.

As summarized in the Employer's Pre-Hearing Report (ALJX 1), the case file contains Fairmont Clinic medical notes, covering the period from July 23, 1966 to March 25, 1988. Although the notes refer to various respiratory or pulmonary conditions, including coal worker's pneumoconiosis, they do not directly address the total disability or causation issues (DX 19-7). In addition, the Employer's Pre-Hearing Report sets forth various physicians' opinions (ALJX 1).

On August 8, 1974, Dr. James H. Walker, Chairman of the West Virginia Occupational Pneumoconiosis Board, found sufficient evidence to justify a diagnosis of "occupational pneumoconiosis in advanced stage" with a resulting 20% impairment in the miner's work capacity (DX 19-12). On March 16, 1977, Dr. Patel diagnosed COPD, which he related to Mr. Kovalck's coal mine employment. In addition, he noted "dyspnea on exertion." However, Dr. Patel did not directly address the total disability issue (DX 18-7).

On August 10, 1979, Dr. Murray Sachs reported that the miner had pneumoconiosis which arose out of coal mine employment. However, Dr. Sachs described the miner's pulmonary impairment as "quite mild," and found that it would not preclude Mr. Kovalck from returning to his last job as a loading machine operator. Accordingly, Dr. Sachs concluded that the miner's age of 66 years was probably a more significant factor than his respiratory impairment in his not returning to work (DX 18-29).

On November 26, 1979, Dr. Ralph J. Jones and James T. Smith co-authored a report, in which they opined that the miner had occupational pneumoconiosis (as shown on x-ray), "with no impairment of capacity for work therefrom" (DX 18-16). However, on February 20, 1981, Dr. A. Carl Walker stated that the miner was totally disabled due to pneumoconiosis (DX 18-16). Furthermore, on July 29, 1988, Dr. D.L. Rasmussen opined that the miner had coal worker's pneumoconiosis arising out of his coal mine employment; that the miner had at least a moderate loss of respiratory functional capacity, which would preclude him from returning to coal mine employment; and, the loss of respiratory function is mainly due to coal worker's pneumoconiosis (DX 19-8).

On December 21, 1988, Dr. Roger Abrahams set forth the following cardiopulmonary diagnoses and their respective etiologies: simple coal worker's pneumoconiosis due to coal dust, COPD emphysema/chronic bronchitis) due to cigarettes & coal dust; and borderline cardiomegaly due to possible coronary artery disease. Dr. Abrahams was somewhat equivocal regarding the total disability issue,

stating: "Based on history patient is impaired to degree that he cannot perform last CME. Based upon objective spirometry & ABG he is not impaired to that degree. Hence, there may be a cardiac component to dyspnea." Regarding the "causation" issue, Dr. Abrahams stated that the miner's borderline cardiomegaly was the major contributing factor, whereas simple pneumoconiosis and COPD contributed "a minor portion to impairment." (DX 19-4).

On November 30, 1990, Dr. John A. Bellotte noted the miner's subjective complaints, including shortness of breath and productive cough; abnormal chest x-ray findings; mild obstructive ventilatory impairment on pulmonary function study; and, a right bundle branch block on EKG. Dr. Bellotte recommended that the miner undergo additional tests, such as a CT scan, possible flexible fiberoptic bronchoscopy, and/or diffusion study to better define the extent of his pulmonary disease. Dr. Bellotte noted that the miner was reluctant to pursue these recommendations (DX 24,104). Notwithstanding the miner's reported reluctance, he returned to Dr. Bellotte on December 12, 1990, and subsequently underwent a flexible fiberoptic bronchoscopy (DX 24,104). In his December 12, 1990, Dr. Bellotte noted that chest x-ray reports had shown increased interstitial markings; and, that the miner had recently undergone chemotherapy for treatment of carcinoma of the colon. In addition, Dr. Bellotte stated that the miner was "mostly concerned with pneumoconiosis problems since he was recently required to return his awarded money. He is very bitter about this and this controls most of the conversation when he is in the office."[7] After canceling his scheduled bronchoscopy on December 18, 1990, the miner underwent the procedure on January 8, 1991. The operative report of Dr. John Bellotte listed him as the surgeon, and described the operation as follows: "Flexible fiberoptic bronchoscopy with sterile brushings, brush biopsies, washings and transbronchial lung biopsies (DX 24,104).

On January 9, 1991, Dr. Cordill de la Pena, the pathologist, made the following diagnosis: "Transbronchial lung biopsy showing reserve cell hyperplasia, submucosal edema, and mild nonspecific inflammatory reaction." (DX 24,104). On January 11, 1991, Dr. Bellotte also reported that the results of the bronchoscopy were negative for malignancy (DX 24, 104). However, an enhanced CT scan of the chest, dated January 8, 1991, revealed "evidence for mediastinal adenopathy ranging in the 1 cm size lymph nodes with a 5 cm mass in the superior pole of the right kidney. Neoplasm is suspected and further evaluation is recommended." (DX 24,104). Subsequently, the pathology report from the Mayo Clinic, dated April 18, 1991, revealed various abnormalities, which entailed surgery involving the following conditions: right upper pole renal tumor (revised); right partial nephrectomy; CT scan two years after hemicolectomy for colon cancer reveal a 6 cm right upper pole tumor; compromised contralateral renal function (revised). (DX 24,104).

On April 29, 1992, Dr. P.V. Devabhaktuni conducted a black lung evaluation. In summary, Dr. Devabhaktuni set forth the following cardiopulmonary diagnoses: "moderate obstructive airways disease,"

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[7] It appears that the miner was temporarily awarded benefits, perhaps based upon the misapplication of the transfer provisions of the 1981 Amendments to the Black Lung Benefits Act (DX 18-4). However, since his claim was subsequently denied, there was an overpayment. Pursuant to a "Joint Motion to Approve Settlement and Remand" (DX 19-23), the miner paid $25,000.00 of the overpayment, and the Black Lung Disability Trust Fund waived the balance of $33,825.50 (DX 19-24).

which he attributed to "cigarette smoking & occupational dust exposure." In addition, Dr. Devabhaktuni noted: "Moderate pulmonary impairment by PFTS. Unable to assess accurately as pulm. Exercise stress test was not maximal and pt stopped due to fatigue with adequate breathing & cardiac reserve." Dr. Devabhaktuni was also somewhat equivocal regarding the etiology of the miner's impairment, stating that "probably most of his impairment is related to moderate obstructive airways disease." However, Dr. Devabhaktuni also listed colon cancer as a non-cardiopulmonary diagnosis which could affect the miner's ability to perform coal mine work (DX 5).

On November 2, 1992, Dr. Joseph J. Renn reported that the miner suffered from chronic bronchitis with obstruction, systemic hypertension, and exogenous obesity, which were unrelated to coal mine dust exposure. Furthermore, Dr. Renn specified that the miner's chronic bronchitis was due to tobacco smoking; he does not have pneumoconiosis; and, the miner's moderate impairment wold not prevent him from performing his last coal mine job as a loading machine operator or any similar work effort (DX 21,40,99). On May 13, 1993, Dr. Gregory J. Fino issued a medical report, in which he reviewed the, then, available evidence. In addition, Dr. Fino reread two chest x-rays as negative for pneumoconiosis. Based upon the foregoing, Dr. Fino stated: there is insufficient objective medical evidence to justify a diagnosis of pneumoconiosis; the miner suffers from a moderate respiratory impairment secondary to cigarette smoking; the miner's respiratory condition is not disabling if the job does not entail any heavy labor, but it is disabling if it requires heavy labor; and, the miner does not suffer from an occupationally acquired pulmonary condition or any respiratory condition related to coal mine dust exposure (DX 26,101).

On November 8, 1993, Dr. Bellotte issued a supplemental report, dated November 8, 1993, in which he reviewed and analyzed the, then, available evidence. Dr. Bellotte found such evidence insufficient to justify a diagnosis of pneumoconiosis, citing the transbronchial lung biopsy results, which were negative for pneumoconiosis. Furthermore, Dr. Bellotte clearly stated that the miner's disability was unrelated to pneumoconiosis. However, Dr. Bellotte was somewhat ambiguous and equivocal regarding the total disability issue. In pertinent part, Dr. Bellotte stated: "There is a moderate obstructive ventilator impairment present, which I believe may be due to his smoking history. This gentleman's last job in the coal mines was that of a loading machine operator, and I believe he would have the pulmonary capacity to work the levers for running the loading machine. However, if he would occasionally have to get out and shovel coal, he would run into difficulty. Nevertheless, with his cardiac condition and his age, I would consider him totally and permanently disabled, and only if his respiratory condition were taken alone would I think he would be able to perform his job as a loading machine operator." (DX 93).

On January 13, 1994, Dr. Renn testified at deposition (DX 34, 91). Dr. Renn discussed the results of the examination and clinical tests, which he conducted on October 30, 1992, as set forth in his November 2, 1992 report. Furthermore, Dr. Renn noted that he had specifically inquired as to the hardest and heaviest aspects of the miner's job as a loading machine operator, in order to understand the rigors of the job, so that he could assess whether the miner retained the physiologic capacity to perform such work (DX 34, 91, pp. 4-6). In addition, Dr. Renn discussed other medical data, as well as the miner's coal mine employment and cigarette smoking histories (DX 34, 91, pp. 7-29). In summary, Dr. Renn stated that, despite the comparatively less extensive cigarette smoking history, the physiologic pattern indicates that the miner suffers from a tobacco-induced obstructive airways disease (DX 34, 91, pp. 26-27). Furthermore, Dr. Renn reiterated that, based upon the miner's duties, as he described, and having

interviewed and examined many other loading machine operator, Mr. Kovalck's "moderate obstructive ventilatory defect was insufficient to prevent him from returning to his prior employment as a loading machine operator." (DX 34, 91, p. 25).

In view of the progressive, irreversible, and latent nature of pneumoconiosis, the more recent medical evidence is generally more relevant and probative. Furthermore, such evidence is clearly more relevant regarding the "death due to pneumoconiosis" issue. Accordingly, I have set forth detailed summaries of the hospital records regarding the miner's treatment shortly before death (DX 7, 87), the miner's death certificate (DX 79,109), the autopsy report by Dr. Ducatman (DX 80, 109), and, the post-autopsy medical (pathology and non-pathology) opinions of Drs. Naeye (DX 90; EX 2), Tomashefski (DX 85; EX 3), Bellotte (DX 83), Fino (DX 82), Renn (DX 81; EX 1), Perper (DX 110), Oesterling (DX 118), and Kahn (CX 1).

Dr. John Shamma'a, an Associate Professor in the Department of Medicine at West Virginia University Hospital, issued a "Procedure Report," dated December 4, 1998, in which Dr. Shamma'a noted that the miner had been diagnosed with adenocarconoma of the stomach in February 1998; the miner had previously underwent an endoscopy; he underwent radiation therapy; and, the miner's family mentioned that he was suffering from more shortness of breath, more diarrhea, ad poor intake. Scans of his abdomen revealed regression of the tumor. The procedure reported by Dr. Shamma'a involved an upper GI endoscopy to check the response to radiation therapy. In summary, Dr. Shamma'a stated:

> IMPRESSION AND RECOMMENDATIONS
> Adenocarcinoma of the distal stomach status post radiation therapy. The mass size of the lesion is approximately the same size as previously, and he has a smaller but substantial satellite lesion in close proximity. There is delayed gastric emptying, but no actual obstruction at the pylorus. The patient also exhibits clinical signs of bronchitis or aspiration pneumonia. He should be managed very conservatively. Feeding should be with thick liquids, very soft solids, but no more substantial (sic). Antibiotics and pain control are suggested as well.

(DX 87).

Dr. Miklos L. Auber, an Associate Professor in the Section of Hematology/Oncology at West Virginia University Hospital, issued a Discharge Summary, regarding the miner's hospitalization from December 4, 1998 to December 9, 1998 (DX 87). The full text of the Discharge Summary is as follows:

> DISCHARGE DIAGNOSES
> 1. Gastric cancer.
> 2. Colon cancer.
> 3. Lung cancer.
> 4. Ruled out for aspiration pneumonia.
> 5. Diarrhea.
> 6. Benign prostatic hypertrophy.

DISCHARGE MEDICATIONS

1. Megace 20 cc daily.
2. Lorazepam 0.5 mg q.h.s.
3. Serevent inhaler.
4. Combivent inhaler.
5. Proscar.
6. Paxil.

REASONS FOR HOSPITALIZATION/SIGNIFICANT FINDINGS/MAJOR PROCEDURES/TREATMENT

The patient is an 85-year-old white male with multiple medical problems, including multiple primary cancers. The patient was admitted after esophagogastroduodenoscopy was performed on December 14, 1998 (sic), for possible aspiration pneumonia and diarrhea. The patient was admitted and aspiration workup was performed which included barium swallow which did not reveal any aspiration. The patient was started on stage I thickened liquids and pureed diet. He required assistance with meals and aspiration precautions. He was also started on intravenous antibiotics on admission for possible pneumonia. However, the patient became afebrile and with decreasing white count. The patient's diarrhea also improved during hospitalization. A gastroenterology consult was obtained and they recommended antibiotics for possible Clostridium difficile as the patient had a significant history of Clostridium difficile in the past. Clostridium difficile toxin was sent; results are still pending. The patient will be started on p.o. vancomycin, as he was previously treated with Flagyl and it was thought that maybe vancomycin would help this time. The patient was discharged to home on Ceftin 500 mg b.i.d., Metamucil to help with the diarrhea, and also vancomycin. The patient is to follow up with Dr. Auber as scheduled.

CONDITION ON DISCHARGE

a. Ambulation: The patient is bedridden.
b. Self-care ability: The patient requires a great deal of assistance with activities of daily living.
c. Cognitive status: The patient was not oriented to time, person, or place.

(DX 87).

Dr. John Rogers, an Associate Professor of Medicine in the Section of Hematology/Oncology at West Virginia University Hospital, issued a Discharge Summary, which Dr. Sarah Zeb, a Resident in Medicine, signed on his behalf, regarding the miner's hospitalization from December 14, 1998 to December 17, 1998 (DX 87). The full text of the Discharge Summary is as follows:

DISCHARGE DIAGNOSES

1. Colon cancer.
2. Gastric cancer.
3. Lung cancer.

4. Chronic obstructive pulmonary disease.
5. Obstructive uropathy.
6. Alzheimer's disease.
7. Patient ruled out for aspiration pneumonia.

DISCHARGE MEDICATIONS

1. Metamucil.
2. Megace 20 cc q.d.
3. Lorazepam 0.5 mg q.h.s.
4. Proscar 5 mg daily.
5. Paxil 20 mg daily.
6. Combivent and Serevent inhalers.
7. Ceftin 500 mg two tablets q. 12h.
8. Flagyl 250 mg one p.o. daily.

HOSPITAL COURSE

The patient is an 85-year-old white gentleman who was recently discharged in the earlier part of this month. At that time, he was ruled out for aspiration pneumonia. The patient's daughter relates that he has had some difficulty breathing at home; therefore, she brought him back to the hospital. They were not following the recommended diet at home. He had a sandwich to eat the day prior to admission. She denied any evidence of choking. No fevers or chills at home. Upon admission to the hospital, the patient was breathing comfortably. Saturations were 98% on two liters. The patient had a chest x-ray which did not reveal any evidence of aspiration. The patient remained afebrile during the course of his hospitalization and white count was low. The patient was started on ceftriaxone and clindamycin intravenously. These were then subsequently changed to p.o. Ceftin and Flagyl. The patient's daughter also relates that he had diarrhea at home; however, he did not have diarrhea in the hospital. Another Clostridium difficile was sent, which was negative and no fecal leukocytes were present. The patient was seen by speech and swallow therapy once again during the course of hospitalization and they explained to the daughter in detail the different types of foods she could offer her father. A social worker was also involved and arrangements were made to help with assistance at home. Surg/Onc consult was obtained during the initial part of his admission as the daughter requested that we have a feeding tube placed in. Surg/Onc saw the patient and they did not feel that he was a surgical candidate for this procedure. The patient is to follow up with Dr. Auber as scheduled.

(DX 87).

Dr. Donald McDowell, a Professor of Surgery in the Section of Vascular Surgery at West Virginia University Hospital, issued a report, dated January 27, 1999, in which he concluded: "There is a deep venous thrombosis involving the femoral and popliteal veins in both lower extremities of this patient (DX 87).

Dr. Paolo Romero, an Assistant Professor of Medicine in the Section of Hematology/Oncology at West Virginia University Hospital, issued a Discharge Summary, which Dr. Leila Vaghei, a Resident in Medicine, signed on his behalf, regarding the miner's final hospitalization from January 17, 1999 until March 2, 1999 (DX 87). The full text of the Discharge Summary is as follows:

> HOSPITAL COURSE
> The patient was an 85-year-old white male with end-stage metastatic gastric cancer with liver metastases as well as colon cancer, status post resection who was admitted for aspiration pneumonia secondary to gastric outlet obstruction. The patient was treated with clindamycin and ceftriaxone, and subsequently developed Clostridium difficile. He was placed on Flagul and his Clostridium difficile infection resolved. The patient continued to aspirate even on a mechanical soft diet. The gastroenterology and surgical oncology services were consulted for possible PEG placement but the patient was deemed to be too high of a risk for this procedure. Therefore, he was placed NPO and received total parenteral nutrition. The patient became afebrile and his antibiotics were discontinued. On the night of March 1, 1999, the patient vomited and aspirated. His oxygen saturation declined and was placed on Venturi facemask. After speaking with the family, the patient's code status became "do not resuscitate." On the night of March 2, 1999, the patient expired. There were no heart or lung sounds on examination. Pupils were nonreactive. No peripheral pulses were able to be felt. The family consented to a limited autopsy of the patient's lungs due to his history of chronic obstructive pulmonary disease/black lung.

(DX 87).

The miner's death certificate, which was signed by Dr. Vikas Sial, states that the Mr. Kovalck died on March 2, 1999, at age 86, of respiratory failure due to aspiration pneumonia and metastatic gastric cancer. Although Dr. Sial noted that an autopsy was performed, it is unclear whether the autopsy findings were available prior to the completion of the cause of death portion of the death certificate (DX 79).

Dr. Barbara S. Ducatman issued an autopsy report, dated April 22, 1999, which summarized her findings regarding the autopsy she conducted on March 3, 1999 (DX 80). The autopsy was restricted to the thorax only. The autopsy report sets forth a clinical history, gross description and findings on microscopic examination. Based upon the foregoing, Dr. Ducatman stated:

> FINAL ANATOMIC DIAGNOSES:
>
> MAJOR DISEASES
>
> 1. Lungs, Combined Weight 1,925 Grams.
>   - A. Neuroendocrine carcinoma with focal squamous differentiation.
>   - B. Metastatic adenocarcinoma of gastrointestinal origin.
>   - C. Coalworkers' pneumoconiosis, moderate.
>   - D. Silicosis, lungs and hilar lymph nodes.
>   - E. Emphysema.

F. Bronchopneumonia with features of aspiration pneumonia.

2. Heart, 500 Grams.
   A. Marked coronary atherosclerosis, right and left ventricular hypertrophy.

SUMMARY AND COMMENTS:
The immediate ad contributing causes of death in this patient could not be determined due to the limited nature of the autopsy. The lungs showed evidence of metastatic adenocarcinoma consistent with the gastrointestinal primary, as well as a nodule of neuroendocrine carcinoma. There was a moderate degree of coalworkers' pneumoconiosis with silicosis.

(DX 80).

Dr. Richard L. Naeye, who is Board-certified in Anatomic and Clinical Pathology (DX 89), issued a report, dated September 3, 1999 (DX 90). Dr. Naeye listed various medical data which he had been provided. In addition, Dr. Naeye noted some inconsistencies in the miner's reported smoking history. Furthermore, Dr. Naeye cited some of the clinical data obtained during the miner's lifetime. Moreover, Dr. Naeye analyzed the autopsy evidence. In conclusion, Dr. Naeye stated:

> INTERPRETATION: The findings of a mild simple coal worker's pneumoconiosis (CWP) are present. These include 2 anthracotic microdocules and a variable number of smaller macules, usually with associated fibrosis and focal emphysema. This CWP was too mild to have caused any disability or contributed in any way to his death. He had normal lung function after he quit mining coal and simple CWP does not advance after quitting the industry. He later developed some airway obstruction, mainly in the small airways which is a characteristic consequence of cigarette smoking, not CWP. Studies of randomly selected populations of coal miners have shown no effect of coal mine dust exposure on life expectancy [Footnote to two citations omitted]. Such expectancy would surely have been reduced if exposure to coal mine dust had caused clinically significant centrilobular emphysema and chronic bronchitis and bronchiolitis. I am not sure whether the adenocarcinoma in his lungs originated in his stomach, colon or some other site because the autopsy was limited to the thoracic cavity. The appearance of neoplasm varies somewhat from area to area in its histologic appearance. This man died as the result of one or more malignant neoplasms that had metastasized to his lungs and perhaps other organs. The immediate cause of death was a rapidly spreading acute lobular pneumonia which had obstructed some airways. As previously mentioned his CWP was too mild to have contributed in any way to his death. It did not hasten his death or cause any disability. Late in life he was disabled by the infirmity of age, one or more metastatic cancers and small airway obstruction which was the consequence of his many years of cigarette smoking.

(DX 90).

Dr. Naeye also testified at deposition on September 23, 2002 (EX 2). On cross-examination, Dr. Naeye acknowledged that the positive autopsy evidence of pneumoconiosis was superior to his early negative chest x-ray reading in 1992; and, that the most recent pulmonary function studies he had reviewed were those conducted on October 30, 1992. In addition, Dr. Naeye described the miner's degree of impairment, in 1992, as moderate. However, Dr. Naeye reiterated that the miner's moderate impairment, in 1992, would not have precluded the miner from engaging in moderate-ro-heavy. Accordingly, it was not totally disabling. Furthermore, Dr. Naeye had found that such impairment was not associated with the miner's coal dust exposure. On the other hand, Dr. Naeye conceded that he could not provide an opinion regarding the degree of the miner's pulmonary impairment shortly before his death, in the absence of more recent studies (EX 2, pp. 20-22). However, based upon his analysis of the available medical evidence, Dr. Naeye reiterated that coal worker's pneumoconiosis did not play a role in causing the miner's pulmonary impairment during his lifetime (EX 2, pp. 19-20), or in causing or hastening the miner's death (EX 2, p. 16).

Dr. Joseph F. Thomashefski, Jr., who is Board-certified in Anatomic and Clinical Pathology (DX 84), issued a report, dated October 96, 1999 (DX 85). Dr. Thomashefski cited the available medical evidence and set forth his own findings on examination of the autopsy slides. In summary, Dr. Thomashefski stated, in pertinent part:

> Based on my review of the medical records, autopsy report, and slides prepared at autopsy, it is my opinion, within reasonable medical certainty, that Mr. Kovalck did have mild simple coalworkers' pneumoconiosis, as verified by the presence of sparse coal macules and microdocules in his lung tissue. Simple coalworkers' pneumoconiosis was of a very low profusion and, in y opinion, within reasonable medical certainty, would not have caused any respiratory symptoms, respiratory impairment, or limitation of his ability to do hard manual labor. The presence of silicotic nodules in his hilar lymph nodes confirms an exposure to silica, which often accompanies coal dust exposure. In my opinion Mr. Kovalck did not have pulmonary silicosis.
>
> It is also my opinion that Mr. Kovalck had severe panacinar bullous emphysema. In his tissue slides, emphysema extends well beyond his lesions of coal workers' pneumoconiosis. Also present if multifocal, acute and organizing aspiration pneumonia, two foci of metastatic adenocarcinoma, suggestive of colonic primary, and focal pleural thickening with features of amyloidosis; however, no similar deposits were seen elsewhere in the lungs or heart, and this isolated pleural finding is considered to be an incidental process of no clinical significance.
>
> Since the autopsy was limited to the thorax, the anatomic cause of death could not be determined with certainty. It is my opinion, however, that Mr. Kovalck's mild, simple coalworkers' pneumoconiosis was not a cause or a contributory factor in his death. It is also my opinion, within reasonable medical certainty, that neither simple coalworkers' pneumoconiosis, nor coal dust exposure, is a cause of colonic or gastric carcinoma, panacinar emphysema, coronary atherosclerosis, or focal pleural amyloidosis. Aspiration pneumonia is a frequent complications of terminal illness, and is not related to coal dust

> exposure or pneumoconiosis. It is therefore my final opinion, within reasonable medical certainty, that Mr. Kovalck's occupational exposure to coal dust neither caused nor contributed to his death. Cigarette smoking, on the other hand, is an important cause of panacinar emphysema and a contributory factor of atherosclerotic heart disease.

(DX 85).

Dr. Tomashefski also testified at deposition on September 28, 2002 (EX 3). On cross-examination, Dr. Tomashefski acknowledged that Mr. Kovalck had a lengthy coal mine employment history, which he reported as 45 years. Furthermore, Dr. Tomashefski conceded that the miner had mild, simple coal worker's pneumoconiosis. Based upon the pulmonary function tests that were performed at the time of the miner's retirement, Dr. Tomashefski found, at that time, the miner did not have any significant pulmonary impairment. However, Dr. Tomashefski acknowledged that the 1992 pulmonary function results showed an obstructive ventilatory impairment, which could have interfered with the miner's ability to perform heavy labor. On the other hand, Dr. Tomashefski reiterated that such impairment was not related to coal worker's pneumoconiosis (EX 3, pp. 29-31). In summary, Dr. Tomashefski testified that pneumoconiosis did not cause any respiratory symptoms or impairment during the miner's lifetime, and it did not contribute to or hasten reiterated the miner's death. In making this determination, Dr. Tomashefski noted that the pneumoconiosis found on autopsy was not extensive; the pulmonary function studies were normal at the time Mr. Kovalck ceased mining; and, this degree of simple pneumoconiosis does not progress to any great extent after one leaves the mine environment (EX 3, pp. 26-27).

Dr. John A. Bellotte, who specializes in Pulmonary Medicine, Flexible Fiberoptic Bronchoscopy, and Occupational Lung Disease, issued a report, dated October 12, 1999 (DX 83). Dr. Bellotte reviewed his own reports, covering the period from January 5, 1979 through November 8, 1993; the West Virginia University Hospital admission, dated December 4, 1998; subsequent admissions and medical records regarding the miner's treatment prior to death; various clinical tests results and interpretations; the autopsy results; and, Dr. Naeye's report. Based upon the foregoing, Dr. Bellotte concluded:

> It is my impression, and I can state with a reasonable degree of medical certainty, that any coal workers' pneumoconiosis present did not have any significant effect on this man's demise. He would have died when he died, how he died, and why he died.

(DX 83). Following the receipt and review of additional medical records, including the findings of Dr. Tomashefski, Dr. Bellotte added an addendum to the report, in which he stated, in pertinent part:

> Essentially Dr. Tomashefski has reviewed the same information I have and came up with similar conclusions. Dr. Tomashefski agrees that the mild simple coal workers' pneumoconiosis would not have caused respiratory symptoms or impairment or limited Mr. Kovalck's ability to do his last coal mining job. However, he had multiple other medical conditions which made him totally and permanently disabled. Almost no organ system in his body had been spared. He had multiple metastatic disease and severe arteriosclerotic coronary artery disease. These diagnosed conditions are not related to coal dust exposure

> and it is my opinion that the panacinar bullous emphysema is much more likely to be associated with cigarette smoking. The aspiration pneumonia is a frequent terminal event and I concur with Dr. Tomashefski that Mr. Kovalck's occupational dust exposure neither contributed to, nor hastened, his expiration.

(DX 83).

Dr. Gregory J. Fino, a B-reader and Board-certified pulmonologist, issued a report, dated October 20, 1999 (DX 82), in which he reviewed the available medical evidence. Dr. Fino noted that, in his prior report, dated May 13, 1993, he had found insufficient medical evidence to justify a diagnosis of pneumoconiosis; and, a moderate respiratory impairment due to cigarette smoking, which disabled Mr. Kovalck from performing heavy labor in the mines. Following his detailed analysis of the additional medical data, Dr. Fino concluded:

1. Simple coal workers' pneumoconiosis was present pathologically.
2. There was a moderate respiratory impairment present which was due to smoking.
3. From a respiratory standpoint, this man was disabled from performing heavy labor.
4. Coal workers' pneumoconiosis did not cause this man's death. He died as a result of cancers which were unrelated to the inhalation of coal mine dust.
5. Coal workers' pneumoconiosis did not contribute to, or hasten, this man's death. He would have died as and when he did had he never stepped foot in the mines.

(DX 82).

Dr. Joseph J. Renn, III, a B-reader who is Board-certified in Internal Medicine, Pulmonary Diseases, and Forensic Medicine (EX 1, pp. 3-4), issued a report, dated November 2, 1999 (DX 81), following his review of Dr. Tomashefski's pathology report. In summary, Dr. Renn stated:

> It is apparent that, pathologically, Mr. Kovalck had mild simple coalworkers' pneumoconiosis, focal emphysema associated with the simple coalworkers' pneumoconiosis, severe panacinar bullous emphysema as a result of tobacco smoking, metastatic adenocarconoma to the lungs suggestive of a colon primary, and aspiration pneumonia which was likely terminal.
>
> Apparently Mr. Kovalck died at the age of 86 years on March 2, 1999, following a hospitalization on January 27, 1999, for treatment of a right lower lobe infiltrate, leukocytosis and dehydration.
>
> It is my opinion, within a reasonable degree of medical certainty, that the mild degree of simple coal workers' pneumoconiosis present in Mr. Kovalck was neither a cause of, nor a contributing factor to his demise. It is with a reasonable degree of medical certainty that Mr. Kovalck's demise occurred when, and in what manner, it would have whether or not he had ever been exposed to coal mine dust and developed the mild degree of simple

coalworkers' pneumoconiosis that was present at the time of his demise.

(DX 81).

Dr. Renn also testified at deposition on September 19, 2002 (EX 1). On cross-examination, Dr. Renn acknowledged that the positive pathology evidence of pneumoconiosis, as found on autopsy in 1999, is superior to his negative finding on chest x-ray in 1992. However, Dr. Renn did not find those results surprising. Furthermore, Dr. Renn, again, acknowledged that the pulmonary function study, which he administered in 1992, revealed a moderate obstructive ventilatory defect. However, Dr. Renn reiterated that such an impairment would not have prevented the miner from engaging in moderate-to-heavy labor at that time. Moreover, Dr. Renn found that the miner's moderate obstructive impairment was unrelated to coal mine employment. Dr. Renn acknowledged, however, that in the absence of more recent pulmonary function studies, he could not provide an opinion as to the degree of the miner's pulmonary impairment shortly before death (EX 1, pp. 20-23). Moreover, Dr. Renn reiterated that coal worker's pneumoconiosis or any coal mine dust-induced lung disease did not play a role in causing any pulmonary impairment during the miner's lifetime (EX 1, pp. 13,19-20), nor did it play any role in causing or hastening the miner's death (EX 1, p. 16).

Dr. Joshua A. Perper, a Forensic Pathologist and Medicolegal Consultant, who is a Clinical Professor of Pathology, Epidemiology and Public Health at University of Miami, issued a report, dated May 28, 2000 (DX 110), in which he reviewed the death certificate, autopsy report, and the autopsy slides. In summary, Dr. Perper concluded:

1. Mr. Kovalck had evidence of simple coal workers' pneumoconiosis mild to moderate, with associated severe centrilobular emphysema.

2. Based on the pathological findings [of] coal workers' pneumoconiosis with presence of silica crystals, it is clear that Mr. Kovalck a former coal miner developed coal workers' pneumoconiosis as a result of an occupational exposure to mixed coal mine dust containing silica.

3. Coal workers' pneumoconiosis with associated centrilobular emphysema had the potential of being a substantial contributory cause in the death of Mr. Kovalck, both directly indirectly through a fatal arrhythmia on the background of hypertensive cardiomegaly and coronary arteriosclerotic disease. However, a reliable evaluation of the role of pneumoconiosis in the death of Mr. Kovalck requires a thorough and full evaluation of his medical records and medical history.

(DX 110).

Dr. Everett F. Oesterling, Jr., who is Board-certified in Anatomical Pathology, Clinical Pathology, and Nuclear Medicine, issued a report, dated August 24, 2000, in which Dr. Oesterling noted that he had an opportunity to review the histologic slides and records. Dr. Oesterling provided a detail analysis of the histological slides while utilizing photomicrophages (DX 118). Dr. Oesterling attached copies of 22

photomicrophages, which he discussed in his report. In addition, Dr. Oesterling sought to address various questions, which apparently were posed by Employer's counsel. Dr. Oesterling stated, in pertinent part:

> This miner did indeed have a mild micronodular coalworkers' pneumoconiosis, the interstitial lesions were all smaller than that noted in this one pleural based nodule. Therefore, I would state with reasonable medical certainty the dust present in this gentleman's lungs appear insufficient to have altered his respiratory function, thus it would not have produced impairment and/or disability during his lifetime. Moreover, it would not have in an way contributed to or hastened his death.
>
> ...The autopsy was limited to the chest to determine the presence of dust related disease, thus the cause of death was not totally delineated. However, indirect evidence is present that would suggest the probable cause of death....(T)his gentleman has experienced at least separate primary tumors plus the metastatic disease illustrated.
>
> This extensive history of malignancies plus the therapies required to try to arrest their growth frequently comprises a major burden on the immune system, the latter being suppressed and resulting in infections including pneumonia....Thus this [abnormality identified on photomicrographs] is a rapidly disseminating bronchopneumonia complicating this gentleman's malignant diseases.
>
> ...[There] are foreign body giant cells suggesting at least some component of this gentleman's pneumonia may have resulted from aspiration of gastric contents. In any event, pneumonia was a significant contributing cause to this gentleman's demise.
>
> ...Obviously, this gentleman suffered a significant coronary artery disease, again a process which may have contributed to his death. In any event, this gentleman's death was not the result of diseases related to mine dust exposure, for neither the malignancies nor the vascular disease illustrated are the result of his mining employment.
>
> Finally [upon analysis of photos 20 through 22]...[a]ny alterations in his respiratory capacity during his lifetime would have been due to the disease illustrated in these three photos, centrilobular progressing to panlobular emphysema. This disease is commonly associated with the use of cigarettes and although it is somewhat varied within the medical records, there is definite historical evidence of a smoking habit. Thus chronic respiratory symptoms would have largely been related to his use of cigarettes and the resultant centrilobular emphysema, not his mining experience.
>
> Hopefully this series of photomicrophages along with the narrative description adequately answers your questions concerning the role of mine dust in producing any significant disease process, as well as its role in his ultimate demise. Dust related disease was not a factor in his lifetime or his terminal disease processes.

(DX 118).

Dr. Jeffrey A. Kahn, a Consulting Pathologist at the Department of Health and Human Services, issued a one-page report, dated October 10, 2002, in which he outlined his findings on examination of the autopsy slides (CX 1). In summary, Dr. Kahn stated:

> The slides contain eight sections of lung tissue and three sections of lymph nodes. Marked pulmonary emphysema is present along with a moderate degree of Coal Workers' Pneumoconiosis (CWP) as evidenced by coal macules in every section of lung, involving approximately 15 - 20% of the terminal respiratory units. Coal nodule formation is not present. Focal bronchopneumonia is also present.
>
> Metastatic carcinoma is present in one section of lung. There is no metastatic disease in the lymph nodes which do have several small fibrous nodules consistent with representing (sic) silicosis.
>
> DIAGNOSES:
>
> Pulmonary Emphysema, marked
> Coal Workers' Pneumoconiosis, Moderate
> Bronchopneumonia
> Metastatic Carcinoma
> Mild Silicosis of Hilar Lymph Nodes

(CX 1).

Discussion and Applicable Law

As set forth above, the Employer conceded, and I find, that Mr. Kovalck had simple coal worker's pneumoconiosis, which arose out of the miner's approximately 42 years of coal mine employment. However, in Judge Kerr's Decision and Order - Rejection of Claim, the "pneumoconiosis" and "causal relationship" issues were not the basis for denying benefits (DX 18-18). Accordingly, those findings do not represent a material change in condition under §725.309. Furthermore, the earliest claims were ultimately denied by the Benefits Review Board on procedural grounds, because of the abandonment of Claimant's appeal (DX 18-42). Similarly, the miner's November 8, 1988 claim was denied by the District Director on the grounds that the miner had failed to establish a material change in conditions, since he had still not established "total disability" and/or "causation" (DX 19-18). Moreover, the November 8, 1988 was also finally denied by the Board on procedural grounds, when the Board dismissed the Claimant's appeal (DX 23). In view of the foregoing, there is a threshold issue of whether the post-final denial evidence establishes a material change in condition under §725.309. As outlined below, I find that a material change in condition has been established based upon the more recent medical evidence. Accordingly, I must make a *de novo* review of the entire record regarding the miner's. Furthermore, even if a material change in conditions had not been established regarding the miner's claim, I would still consider all the relevant evidence in the widow's case.

As outlined above, the pulmonary function study evidence from March 9, 1970 through November

30, 1990 was clearly nonqualifying under the regulatory criteria set forth in Part 718, Appendix B. However, the studies during the period from April 17, 1991 to October 30, 1992 were mixed. Even if I accord greater weight to the more recent studies, I find that such evidence is inconclusive.[8] Accordingly, total disability has not been established under §718.204(b)(2)(i).

As stated above, the early arterial blood gas studies were mixed. However, the more recent arterial blood gas tests were not qualifying under the applicable standards stated in Part 718, Appendix C. Therefore, total disability has not been established under §718.204(b)(2)(ii).

Notwithstanding medical evidence which indicates that the miner had heart disease, the evidence does not establish that the miner suffered from cor pulmonale with right-sided congestive heart failure. Accordingly, the Claimant has not established total disability under§718.204(b)(2)(iii).

As outlined above, in 1974, Dr. James H. Walker found a 20% impairment due to pneumoconiosis, but did not directly address the total disability issue. In 1977, Dr. Patel diagnosed COPD, which he related to coal mine employment, but he did not assess the miner's impairment or address the total disability issue. In 1979, Dr. Sachs diagnosed pneumoconiosis due to coal mine employment, but found the miner's "quite mild" impairment would not prevent him from performing his last usual coal mine job. Instead, Dr. Sachs attributed the miner's inability to return to work to age. In 1979, Drs. Jones and Smith diagnosed occupational pneumoconiosis, but found no impairment therefrom. In 1981, Dr. A. Carl Walker concluded that the miner was totally disabled due to pneumoconiosis. In 1988, Dr. Rasmussen opined that the miner's moderate respiratory impairment was primarily due to pneumoconiosis, and that such impairment was totally disabling. In 1988, Dr. Abrahams diagnosed pneumoconiosis; related the miner's respiratory problems to cigarettes and coal dust; and equivocally stated that the miner was totally disabled by history, but not totally disabled based on the objective medical data. In 1992, Dr. Devabhaktuni described the miner's pulmonary impairment as moderate; and, he related the condition to cigarette smoking and occupational dust exposure. However, Dr. Devabhaktuni noted problems in assessing the miner's condition on a pulmonary exercise stress test. Furthermore, he did not directly address the total disability issue.

Dr. Bellotte, who had treated the miner, issued multiple reports in 1990, 1991, 1993, and 1999. Although Dr. Bellotte had earlier found insufficient evidence to warrant a diagnosis of pneumoconiosis, he ultimately concluded that Mr. Kovalck had mild simple pneumoconiosis, as shown on autopsy. However, Dr. Bellotte also stated that the miner's pneumoconiosis did not play a role in the miner's respiratory condition during lifetime and/or in the miner's death.

Dr. Renn issued reports in 1992 and 1999; he also testified at deposition in 1994 and 1999. Dr. Renn's earlier findings were that the miner had failed to establish the presence of pneumoconiosis. Subsequently, Dr. Renn acknowledged pathology evidence of mild simple pneumoconiosis. Dr. Renn

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[8] Unfortunately, the record does not contain any pulmonary function studies after October 30, 1992. Thus, there is no pulmonary function study evidence which demonstrates the miner's respiratory or pulmonary capacity closer to the miner's demise in 1999.

repeatedly described the miner's respiratory condition as a moderate obstructive impairment, which he found would not prevent the miner from performing moderate to heavy labor. Moreover, Dr. Renn opined that such impairment was unrelated to pneumoconiosis and/or coal dust exposure. Furthermore, Dr. Renn found that neither pneumoconiosis nor any coal mine related disease caused or hastened the miner's death.

The hospital records describe the miner's treatment for multiple medical problems prior to his death. Although chronic obstructive pulmonary disease is mentioned among various discharge diagnoses, in December 1998, and, aspiration pneumonia secondary to gastric outlet obstruction is also noted in the terminal Discharge Summary authored by Dr. Romero, the focus of the hospital records are on the miner's colon, gastric, and lung cancer. Furthermore, the medical findings set forth in the hospital records do not directly address the total disability or causation issues.

The death certificate does not mention pneumoconiosis. However, it is accorded little weight, since it is unclear whether the autopsy findings were available at the time of its completion.

As set forth above, Dr. Ducatman's autopsy report included a diagnosis of moderate coal worker's pneumoconiosis among various conditions. However, she did not address the total disability or causation issues.

Dr. Naeye found autopsy evidence of a mild pneumoconiosis and, a moderate respiratory impairment, as found on 1992 pulmonary function studies. However, Dr. Naeye opined that such an impairment was not totally disabling; that the miner's pneumoconiosis did not cause or contribute to such impairment; and, pneumoconiosis did not cause or hasten the miner's death.

Dr. Tomashefski also found autopsy evidence of a mild pneumoconiosis, as well as a . moderate respiratory impairment based on the 1992 pulmonary function studies. He testified that such an impairment could interfere with the miner's ability to perform heavy labor. However, Dr. Tomashefski stated that the miner's pneumoconiosis did not cause or contribute to such impairment; and, pneumoconiosis did not play any role in the miner's death.

Dr. Fino issued reports in 1993 and 1999. Dr. Fino initially found the evidence was insufficient to justify a diagnosis of pneumoconiosis. Subsequently, Dr. Fino acknowledged pathology evidence of simple pneumoconiosis. Dr. Fino repeatedly described the miner's respiratory condition as a moderate respiratory impairment, which he found would preclude the miner from performing heavy labor. However, Dr. Fino stated that such impairment was unrelated to pneumoconiosis and/or coal dust inhalation. Furthermore, Dr. Fino opined that pneumoconiosis did not contribute to, or hasten, the miner's death.

Dr. Perper diagnosed mild to moderate simple pneumoconiosis with associated severe centrilobular emphysema on autopsy. He stated, somewhat ambiguously, that the foregoing conditions "had the potential of being a substantial contributory cause" of the miner's death. Moreover, Dr. Perper acknowledged that, in order to obtain a reliable evaluation of the role of pneumoconiosis in the miner's death, a thorough and full evaluation of his medical records and medical history were required.

Dr. Oesterling diagnosed mild micronodular coal worker's pneumoconiosis on autopsy. Although

he did not address the total disability issue, he found that the foregoing diagnosed condition was insufficient to have contributed to the miner's respiratory problems during lifetime and/or to his terminal disease process.

Dr. Kahn diagnosed moderate coal worker's pneumoconiosis and marked pulmonary emphysema among various conditions on autopsy. However, Dr. Kahn did not address the total disability or causation issues.

Having carefully considered the medical opinion evidence, I find that the Claimant has met his burden of establishing the presence of a totally disabling respiratory or pulmonary impairment by a slim preponderance of such evidence. As summarized above, the early medical opinion evidence, through November 29, 1979, indicated that Mr. Kovalck's respiratory or pulmonary impairment was, at most, a mild one. In February 20, 1981, Dr. A Carl Walker found a severe, totally disabling impairment. However, since Dr. Rasmussen's report, dated July 29, 1988, the general consensus among the physicians is that Mr. Kovalck suffered from a "moderate" respiratory or pulmonary impairment. Although there are disagreements among the physicians as to whether the miner's moderate impairment would prevent the miner from engaging in his last usual coal mine job, such differences of opinion are primarily based upon the physicians' characterization of the miner's job duties as "heavy" or "moderate." However, the exertional requirements of the miner's coal mine work is ultimately a determination which must be made by the fact-finder. In that capacity, I have considered the conflicting medical opinions in conjunction with the exertional requirements of the Claimant's last usual coal mine job. As a loading machine operator, the job primarily entailed sitting and operating the loader. However, the miner testified that the job also entailed handling cables, helping drill holes, shoveling, and helping hang tubes. Based upon the credible medical findings of a moderate respiratory impairment and the miner's description of his last usual coal mine job, I concur with those physicians who found that Mr. Kovalck would have been disabled from performing the heavier duties of his job as loading machine operator. Therefore, Claimant has established total disability under §718.204(b)(2)(iv).

Having found total disability on the basis of the medical opinion evidence, I must weigh all of the contrary and probative evidence together to determine if Claimant has established total disability under Section 718.204(b) overall. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986).

Based upon my thorough of the record, I find that the early medical evidence failed to establish total disability, and the preponderance of the arterial blood gas evidence is nonqualifying. Although the pulmonary function evidence neither precludes nor establishes total disability under the criteria set forth in Part 718, Appendix B, the abnormal results, as demonstrated on the more recent pulmonary function studies, support those physicians' who assessed the degree of impairment as "moderate." As discussed above, such an impairment, would preclude the miner from performing the heavier aspects of his last usual coal mine job. Therefore, taken as a whole, I find that total disability has been established under §718.204(b).

Causation

Although Clamant has established that Mr. Kovalck had pneumoconiosis arising from his coal mine work, and, that he was totally disabled by a respiratory or pulmonary impairment, in order to be eligible for benefits in the miner's claim, Claimant still has the burden of establishing that the disability was due to pneumoconiosis.[9]

Under the provisions of §718.204(c)(1), a "miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." Furthermore, the regulations state, in pertinent part:

> ...Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:
> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. §718.204(c)(1)(i),(ii).

As outlined above, several of the early medical opinions attributed the miner's respiratory impairment (whether disabling or not), at least in part, to pneumoconiosis and/or the miner's occupational dust exposure. Furthermore, Dr. A. Carl Walker and Dr. D.L. Rasmussen clearly stated that the miner was totally disabled due to pneumoconiosis, in reports, dated February 20, 1981 and July 29, 1988, respectively. In addition, on December 21, 1988, Dr. Roger Abrahams reported a more equivocal finding of total disability, which he partially attributed to pneumoconiosis and COPD. However, the foregoing physicians did not have the benefit of the more recent clinical test results, hospital records, and autopsy evidence. Furthermore, the early medical opinion evidence, which was obtained many years prior to the miner's death, obviously did not address the death due to pneumoconiosis issue.

Among the more recent medical opinions, virtually all of the physicians who addressed the causation issue found that the miner's respiratory or pulmonary impairment is not due to pneumoconiosis and/or occupational dust exposure. This includes the opinions of Board-certified pathologists, such as Drs. Naeye, Tomashefski, and Oesterling, and Board-certified pulmonary specialists, such as Drs. Bellotte, Fino, and Renn. I find that the recent opinions of the foregoing physicians are well-reasoned and well-documented, and based upon a more extensive analysis and review of the newer, more probative medical evidence. Moreover, I find Dr. Bellotte's opinion to be particularly persuasive. In so finding, I note that

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[9] In "Claimant's Final Summation," page 2, counsel asserts that "the progressive nature of the disease [*i.e.*,pneumoconiosis] confirmed by autopsy study...invoke[s] the necessary statutory presumptive (sic) to support an award of benefits up to the date of the miner's death." However, the miner's current claim was filed on March 20, 1992. Accordingly, there is no statutory or regulatory presumption of entitlement. To the contrary, the Claimant has the burden of establishing each element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 BLR 1-4 (1986)(*en* banc).

Dr. Bellotte not only reviewed the medical evidence, but also he had treated the miner in the early 1990's for the miner's respiratory problems.

Having carefully considered all of the medical opinion evidence, I, therefore, find that the more recent opinions of Drs. Naeye, Tomashefski, Oesterling, Fino, Renn, and, particularly, Dr. Bellotte, far outweigh the contrary conclusions of Drs. Walker, Rasmussen, and Abrahams. Accordingly, Claimant has failed to establish that pneumoconiosis was a "substantially contributing cause" of the miner's total respiratory disability, as defined in 20 C.F.R. §718.204(c)(1).

Death due to Pneumoconiosis

Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by §718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at §718.304 is applicable.
>
> (4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.
>
> (5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. §718.205(c).

As outlined above, Dr. Perper's report, dated May 28, 2000, is the medical opinion which is *most* favorable to the Claimant regarding the "death due to pneumoconiosis" issue. Although Dr. Perper is a well-credentialed pathologist, his conclusion that "[c]oal workers' pneumoconiosis with associated centrilobular emphysema *had the potential of being a substantial contributory cause in the death of Mr. Kovalck*," is equivocal and ambiguous. Moreover, Dr. Perper acknowledged that "*a reliable evaluation of the role of the pneumoconiosis in the death of Mr. Kovalck, requires a thorough and full evaluation of his medical records and medical history*." (DX 110) (Emphasis added). In view of the foregoing, I accord little weight to Dr. Perper's opinion.

Claimant also relies on the autopsy findings of Dr. Ducatman (DX 80,109) and Dr. Kahn (CX 1), who described the extent of the miner's pneumoconiosis as "moderate." However, neither Dr. Ducatman nor Dr. Kahn addressed the "death due to pneumoconiosis" issue. Therefore, their opinions are also entitled to little weight.

On the other hand, the record contains the well-reasoned and documented medical opinions of Drs. Naeye, Tomashefski, Oesterling, Bellotte, Fino, and Renn, who found that the miner's pneumoconiosis did not cause, contribute to, or hasten the miner's death. Not only are the foregoing physicians well-credentialed pathologists or pulmonary specialists, but also, they had the benefit of reviewing the miner's records and medical history. Furthermore, as previously stated, Dr. Bellotte had been the miner's treating physician. In view of the foregoing, I find that the Claimant has clearly failed to meet her burden of establishing death due to pneumoconiosis under §718.205(c), or by any other means.

Conclusion

Although the Claimant has established that the miner had simple pneumoconiosis and suffered from a totally disabling respiratory or pulmonary impairment, the evidence does not establish that the miner was totally disabled due to pneumoconiosis. Furthermore, the evidence does not establish that pneumoconiosis caused, substantially contributed to, or hastened the miner's death. Accordingly, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

ORDER

The claims of Frank Kovalck and Anna Kovalck, his surviving spouse, for black lung benefits under the Act are hereby **DENIED**.

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ROBERT J. LESNICK
Administrative Law Judge

RJL/MP/dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.